Foo Fio Na v Dr Soo Fook Mun & Anor

FEDERAL COURT (PUTRAJAYA) — CIVIL APPEAL NO 02–20 OF 2001(W)
MOHAMED DZAIDIN CHIEF JUSTICE, AHMAD FAIRUZ CJ (MALAYA) AND SITI NORMA YAAKOB FCJ
29 DECEMBER 2006

Professions — Medical practitioners — Negligence — Standard of care — Test to be applied — Negligence of orthopaedic surgeon — Whether Bolam Test applied — Whether practitioner duty bound to inform patient of risks of treatment

Tort — Negligence — Standard of care — Medical negligence — Negligence of Orthopaedic surgeon — Whether Bolam Test applied — Whether practitioner duty bound to inform patient of risks of treatment

Tort — Negligence — Professional negligence — Standard of care — Test to be applied — Negligence of orthopaedic surgeon — Whether Bolam Test applied — Whether practitioner duty bound to inform patient of risks of treatment

The appellant was involved in an accident on 11 July 1982 which resulted in her being warded at the second respondent hospital ('the hospital'). She suffered, inter alia, a closed dislocation C4 and C5 vertebrae with bilaterally locket facets. The first respondent was the orthopedic surgeon on duty who treated the appellant. Despite three attempts, the first respondent failed to reduce the dislocated cervical vertebrae and on 19 July 1982, the first respondent performed the first of two operations to place the dislocated vertebrae into their original positions. This involved an open reduction whereby the nape of the appellant's neck was surgically opened and the dislocated vertebrae moved to their normal positions and secured by bone grafting and the insertion of a loop of wire to stabilise the spinal cord. X-rays were taken after the surgery. Unfortunately this procedure too failed as the appellant became paralysed the day after the operation. Dr Mohandas, a neurosurgeon found that the wire loop which was placed to correct the dislocation of C4 and C5 vertebrae during the first operation was pressuring the spinal cord and that was the cause of the total paralysis. As a result of this the first respondent performed a second operation on the appellant on the same day whereby he removed the wire loop. But this treatment too did not remove the paralysis and the appellant continued to be confined to a wheel chair to this very day. In her medical negligence suit filed against the first and second respondents in January 1987, the appellant succeeded at the High Court in proving that: (1) her paralysis was caused by the first operation performed by the first respondent and was not due to the motor car accident; (2) the first respondent was negligent in tying the wire loop which compressed the spinal cord and which led to the paralysis; (3) the first respondent was

also negligent in not doing anything immediately after the discovery of the paralysis to remedy it; and (4) that the first respondent was negligent when he performed the second operation in the absence of Dr Mohandas who pointed out the cause of the paralysis. As for the second respondent, since it was proven that the first respondent was at all material times its servant or agent, the second respondent was held vicariously liable for the negligent acts of the first respondent. On the respondents' appeal, the Court of Appeal allowed both appeals, set aside the orders of the High Court and ordered that appellant bear the costs of both appeals as well as the trial. Following this, the appellant successfully applied for and obtained leave to appeal to this court to determine the following question of law: Whether the *Bolam Test* as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence.

Held, allowing the appeal:

(1) The *Bolam Test* has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment (see para 37).

(2) There is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium than the *Bolam Test.* On that the question posed to this court was answered in the negative. The appeal was allowed and the orders of the High Court on quantum are to be restored (see paras 71–72).

[Bahasa Malaysia summary

Perayu telah terlibat di dalam satu kemalangan pada 11 Julai 1982 yang menyebabkan beliau dimasukkan ke wad di hospital responden kedua (hospital tersebut). Beliau antara lainnya mengalami, terkehel C4 dan C5 'vertebrae' dengan 'bilaterally locket facet'. Responden pertama adalah pakar bedah ortopedik yang bertugas yang merawat perayu. Walaupun tiga cubaan, responden pertama gagal untuk mengurangkan 'cervical vertebrae' yang terkehel dan pada 19 Julai 1982, responden pertama telah menjalankan pembedahan pertama daripada dua pembedahan untuk memperbetulkan 'vertebrae' yang terkehel ke posisi yang sebenar. Ini melibatkan pemotongan terbuka di mana tengkuk daripada leher perayu telah dibedah secara terbuka dan 'vertebrae' yang terkehel diubah ke posisi yang normal dan dilindungi dengan cantuman tulang dan memasukkan gelungan dawai untuk

menstabilkan saraf tunjang. X-ray telah diambil selepas pembedahan. Walau bagaimanapun, prosedur ini juga gagal yang mana perayu menjadi lumpuh sehari selepas pembedahan. Dr Mohandas, seorang pakar bedah saraf mendapati bahawa gelungan dawai yang digunakan untuk memperbetulkan C4 dan C5 'vertebrae' yang terkehel semasa pembedahan pertama telah menekan saraf tunjang dan ia telah menyebabkan lumpuh keseluruhannya. Disebabkan perkara tersebut responden pertama telah menjalankan pembedahan kedua terhadap perayu pada hari yang sama yang mana beliau mengeluarkan gelungan dawai tersebut. Tetapi rawatan ini juga tidak menghilangkan kelumpuhan dan perayu terus dibatasi dengan kerusi roda setiap hari. Di dalam tindakan kecuaian perubatannya yang difailkan terhadap responden pertama da kedua pada Januari 1987, perayu berjaya membuktikan di Mahkamah Tinggi bahawa: (1) kelumpuhan beliau adalah disebabkan oleh pembedahan pertama yang dilakukan oleh responden pertama dan bukannya disebabkan oleh kemalangan jalanraya; (2) responden pertama adalah cuai dalam mengikat gelungan dawai yang menekan saraf tunjang dan menyebabkan kelumpuhan; (3) responden pertama juga cuai dalam tidak melakukan apa-apa dengan segera selepas mendapati kelumpuhan tersebut untuk memperbetulkannya; dan (4) bahawa responden pertama adalah cuai apabila beliau melakukan pembedahan kedua dengan ketiadaan Dr Mohandas yang menunjukkan sebab kelumpuhan. Terhadap responden kedua, apabila ianya telah dibuktikan bahawa responden pertama adalah pada setiap masa yang material adalah yang berkhidmat atau agennya, responden kedua telah diputuskan bertanggungan vikarius atas kecuaian responden pertama. Di dalam rayuan responden-responden, Mahkamah Rayuan membenarkan rayuan kedua-duanya, mengenepikan perintah Mahkamah Tinggi dan memerintahkan perayu menanggung kos kedua-dua rayuan begitu juga dengan perbicaraan. Berikutan dengan ini, perayu berjaya memohon untuk dan mendapatkan kebenaran merayu ke mahkamah ini untuk menentukan persoalan perundangan berikut: sama ada *Ujian Bolam* seperti mana yang dinyatakan di dalam *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 dalam bidang kecuaian perubatan perlu dipakai di dalam kesemua aspek kecuaian perubatan.

Diputuskan, membenarkan rayuan tersebut:

(1) *Ujian Bolam* adalah tidak releven kepada tugas dan piawaian pemeliharaan pengamal perubatan dalam menyediakan nasihat kepada pesakit di atas risiko yang material dan sedia ada terhadap rawatan yang dicadangkan. Tugas pengamal adalah terikat dengan undang-undang untuk memberitahu pesakitnya yang mana mampu memahami dan menghargai maklumat risiko yang ada di dalam apa-apa rawatan yang dicadangkan untuk membolehkan pesakit untuk membuat pemilihan sama ada untuk meneruskan dengan rawatan yang dicadangkan dengan mengetahui risiko yang ada atau menolak terhadap rawatan tersebut (lihat perenggan 37).

(2) Adalah diperlukan untuk ahli profesion perubatan untuk mengakui kesilapan jika ada, seperti mana kes profesional dalam profesion yang lain. Dalam melakukan sedemikian, mereka yang terlibat di dalam kes kecuaian perubatan boleh mendapatkan nasihat profesional yang terbaik dan mahkamah boleh menilai dengan bukti yang mana boleh membantu mereka di dalam pertimbangan mereka. Atas dasar ini ujian *Rogers v Whitaker* adalah lebih sesuai

dan ujian yang berdaya maju untuk melenium ini daripada *Ujian Bolam.* Di dalam persoalan yang diajukan ke mahkamah ini adalah dijawab secara negatif. Rayuan adalah dibenarkan dan perintah Mahkamah Tinggi berkenaan kuantum adalah dikekalkan (lihat perenggan 71–72).]

Notes

For cases on medical practitioner's negligence, see 10 *Mallal's Digest* (4th Ed, 2002 Reissue) paras 1546–1555.

For cases on standard of care, see 12 *Mallal's Digest* (4th Ed, 2002 Reissue) paras 1304–1306.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2002 Reissue) paras 945–1013.

Cases referred to

Asiah bte Kamsah v Dr Rajinder Singh & Ors [2002] 1 MLJ (refd)
Battersby v Tottman [1984] 35 SASR 577 (refd)
Best v Wellcome Foundation Ltd [1994] 5 Med LR 81 (refd)
Blenkiron v Great Central Gas Consumers' Co [1860] 2 F & F 437 (refd)
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (not folld)
Bolitho (administratix of the estate of Bolitho (deceased) v City and Hackney Health Authority [1997] 4 All ER 771 (refd)
China Airlines Ltd v Maltran Air Corp Sdn Bhd and another appeal [1996] 2 MLJ 517 (refd)
Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45 (refd)
Elizabeth Choo v Government of Malaysia [1970] 2 MLJ 171 (refd)
F v R [1983] 33 SASR 189 (refd)
Foo Fio Na v Dr Soo Fook Mun & Ors [2002] 2 MLJ 129 (refd)
Gascoine v Ian Sheridan & Co [1994] 5 Med LR 437 (refd)
Hajgato v London Health Association [1982] 36 OR(2d) 669 (refd)
Hor Sai Hong & Anor v University Hospital & Anor [2002] 5 MLJ 167 (refd)
Hucks v Cole [1993] 4 Med LR 393 (refd)
Joyce v Wandworth Health Authority [1995] 6 Med LR 60 (refd)
Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor [1996] 4 MLJ 674 (refd)
Kow Nam Seng v Nagamah & Ors [1982] 1 MLJ 128 (refd)
Liew Sin Kiong v Dr Sharon DM Paulraj [1996] 5 MLJ 193 (refd)
Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635 (refd)
Naxakis v Western General Hospital & Anor [1999] 162 ALR 540 (refd)
R Bateman [1925] 94 LBKB 79 (refd)
Renal Link (KL) Sdn Bhd v Dato Dr Harnam Singh [1997] 2 MLJ 373 (refd)
Rogers v Whitaker [1992] 175 CLR 479 (folld)
Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors [1985] 1 AC 871 (refd)
Swamy v Matthews [1967] 1 MLJ 142 (refd)
Swamy v Matthews [1968] 1 MLJ 138 (refd)
Tan Ah Kau v The Government of Malaysia [1997] 2 AMR 1382 (refd)

Legislation referred to

Courts of Judicature Act 1964 s 78(1)

Loh Siew Cheang (Rajashree Suppiah and Lee Sing Teong with him) (Cheang & Ariff) for the appellant.
PS Ranjan (MS Dhillon with him) (PS Ranjan & Co) for first respondent.
GL Ambrose (AY Varughese with him) (Chooi & Co) for second respondent.

Siti Norma Yaakob FCJ (now CJ (Malaya), delivering judgment of the court):

[1] The question of law that is posed to us in this appeal is couched in the following words.

> Whether the *Bolam Test* as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence?

[2] To appreciate the *Bolam Test* which is the touchstone of liability for medical negligence in England, it is necessary that we first consider the facts of the case itself.

[3] The plaintiff in *Bolam's* case, one John Hector Bolam, a salesman, was admitted to Friern Hospital suffering from the after effects of a mental illness of the depressive type. He was examined by the consultant psychiatrist attached to the hospital and was advised to undergo electro-convulsive therapy which was carried out by placing electrodes on the head to allow an electric current from a machine to pass through the brain. One of the results of the treatment was to cause convulsion in the nature of a fit. The consultant psychiatrist did not warn Bolam of the risks involved, one of which was the risk of fracture.

[4] Bolam signed a form consenting to the treatment and nothing untoward happened to him when he received the treatment for the first time. However on the second occasion the treatment was administered by Dr C Allfrey, a senior registrar at the hospital. An initial shock was passed through Bolam's brain for approximately one second and was followed within approximately four seconds by a succession of five momentary shocks administered for the purpose of damping the amplitude of the jerking movements of Bolam's body. No further shocks were administered and the convulsion was not unusually violent. The voltage of the current was 150 volts, the frequency fifty cycles per second.

[5] During this treatment, Bolam lay in a supine position with a pillow placed under his back and his lower jaw was supported by a mouth gag. Otherwise he was not restrained in any way, although a male nurse stood at each side of him in case he should fall from his bed. No relaxant drugs were administered to Bolam prior to the treatment.

[6] In the course of this treatment, Bolam sustained severe physical injuries consisting in the dislocation of both hip joints with fractures of the pelvis on each side which were caused by the head of the femur on each side being driven through the acetabulum or cup of the pelvis.

[7] In claiming damages for his injuries against the management of the hospital, Bolam contended that the hospital was vicariously negligent in permitting Dr Allfrey to administer electro-convulsive therapy without the previous administration of a relaxant drug which would have excluded the risk of fracture altogether or without restraining his convulsive movements by manual control and in failing to warn him of the risk he was taking in consenting to have the treatment.

[8] The medical evidence at the trial showed that competent doctors held divergent views on the desirability of using relaxant drugs and restraining the patient's body by manual control and also on the question of warning a patient of the risks of electro-convulsive therapy. The other medical evidence that was most significant was that the risk of fracture was 1 in 10,000.

[9] In the course of his summing up to the jury, the trial judge, McNair J, made the following remarks on the standard of proof in a medical negligence suit:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

[10] Later when analyzing that standard of proof the learned judge made the following conclusive statement regarding a doctor's duty of care:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that medical act... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view.

[11] Relying on that direction which is now accepted as the *Bolam Test* or *Bolam Principle* and the divergent medical evidence, the jury found that the hospital was not negligent. There are two limbs to the *Bolam Test*. The first is the requirement of a professional person in this case a doctor, to exercise reasonable care in undertaking the task associated with his particular professional calling. The second being commonly invoked, is the assertion that a defendant doctor will not be liable under the first limb if he has complied with a responsible professional practice, allowing for the possibility that there may be more than one such practice.

[12] The legal position as enunciated by McNair J therefore contains the important elements that the doctor must have acted in accordance with an *accepted medical practice*; and that the accepted practice must be regarded as proper by *a responsible body of medical men* in that art.

Bolam's case is distinguishable from the following factors.

(1) The medical evidence showed that the risk of fracture was 1 in 10,000;

(2) Electro-convulsive therapy was a break through in the treatment of a person suffering from a particular type of disorder where before such a person had little or no hope of recovery whatsoever. Today he has a real chance of recovery;

(3) The hospital's alleged negligence can be summarized into the following three categories:

(i) Failure to give Bolam a warning of the risks involved in electro-convulsive therapy so that he might have had a chance to decide whether he was going to take those risks or not;

(ii) Failure to use any relevant drugs which, if used, could have excluded the risk of fracture altogether;

(iii) That if relevant drugs were not used then at least some form of manual control beyond shoulder control, support of the chin and placing a pillow under the back should have been used.

[13] Bolam testified he was not given any warning as to risks, nor asked whether he would not undergo treatment as there is a one in 10,000 risk involved.

[14] In the instant appeal, the facts insofar as they were not disputed happened in the following manner.

[15] The appellant was a front seat passenger in a motor car that crashed into a tree on the night of 11 July 1982. The car was driven by her boyfriend and there were two other passengers in the back seat. The accident happened near Assunta Hospital ('the hospital') where the appellant and her two companions were brought to and where the appellant was subsequently warded for the following injuries.

(1) bruises on the lower abdominal wall;

(2) bruises on the right breast;

(3) bruises on both anterior iliac spine areas;

(4) closed dislocation C4 and C5 vetebrae with bilaterally locked facets.

[16] Injury No (4), the most serious of her injuries caused much pain to her neck each time she moved her head. Dr Celine Pereira, the doctor on duty, prescribed the initial treatment by having X-rays taken of her neck and placing a cervical collar around it. Dr Celine Pereira then contacted the orthopaedic surgeon on duty Dr Soo Fook Mun, the first respondent, who was at home at that time and she was advised that the collar should remain and the appellant stabilised by keeping her in bed and placing sandbags on either side of her head to prevent her from moving her head and to reduce the risk of paralysis. This was accordingly done.

[17] The first respondent saw the appellant for the first time the following morning and after examining her, prescribed the first treatment by placing her on traction with weights in a further attempt to reduce the dislocated cervical vertebrae. This proved to be unsuccessful and on 14 July 1982, the first respondent performed a manipulation or closed reduction procedure under general anaesthetic to unlock the

locked facet joint. Despite three attempts, the first respondent failed to reduce the dislocated cervical vertebrae and on 19 July 1982, the first respondent performed the first of two operations to place the dislocated vertebrae into their original positions. This involved an open reduction whereby the nape of the appellant's neck was surgically opened and the dislocated vertebrae moved to their normal positions and secured by bone grafting and the insertion of a loop of wire to stabilise the spinal cord. X-rays were taken after the surgery.

[18] Unfortunately, this procedure too failed as the appellant became paralysed the day after the operation. Suspecting that the paralysis might be due to vascular infarction, ie when blood supply to the spinal cord is interrupted and cut-off, the first respondent prescribed a course of medication to the appellant by the injection of dexamethasone for over four days. When the appellant's condition showed no signs of improvement the first respondent called in a neurosurgeon, Dr Mohandas, to examine the appellant. Following his examination, Dr Mohandas did a myelogram test on her on 5 August 1982 and he found that the wire loop which was placed to correct the dislocation of C4 and C5 vertebrae during the first operation was pressuring the spinal cord and that was the cause of the total paralysis. As a result of this the first respondent performed a second operation on the appellant on the same day whereby he removed the wire loop. But this treatment too did not remove the paralysis and the appellant continued to be confined to a wheelchair to this very day.

[19] In her medical negligence, suit filed against the first and second respondents in January 1987, the appellant succeded in proving that:

(1) her paralysis was caused by the first operation performed by the first respondent and was not due to the motor car accident;

(2) the first respondent was negligent in tying the wire loop which compressed the spinal cord and which led to the paralysis;

(3) the first respondent was also negligent in not doing anything immediately after the discovery of the paralysis to remedy it; and

(4) that the first respondent was negligent when he performed the second operation in the absence of Dr Mohandas who pointed out the cause of the paralysis.

[20] As for the second respondent, since it was proven that the first respondent was at all material times its servant or agent, the second respondent was held vicariously liable for the negligent acts of the first respondent.

[21] Pursuant to the finding of fault on the part of both respondents and the award of damages against them separate notices of appeal were filed by the first respondent against the appellant and second respondent and by the second respondent against the appellant and first respondent to the Court of Appeal.

[22] Both appeals were heard together at the end of which the Court of Appeal allowed both appeals, set aside the orders of the High Court and ordered that appellant bear the costs of both appeals as well as the trial. Following this, the

appellant successfully applied for and obtained leave to appeal to this court to determine the question of law which is already stated at the beginning of this judgment.

[23] In granting such leave, Steve Shim CJ (Sabah & Sarawak), Abdul Malek and Mokhtar Abullah FCJJ, have in their unanimous judgment reported at [2002] 2 MLJ 129, confined that question of law to *the particular aspect of medical negligence [that] relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment.*

[24] At common law, the duty of care owed by a doctor arises out of his relationship with his patient. Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advice and treat his patient.

[25] That duty of care has been aptly described by Lord Hewart CJ in *R Bateman* [1925] 94 LBKB 79 to be as follows:

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.

[26] However in the exercise of his duty of care, the doctor is expected to maintain a standard which under the common law is achieved by the standard satisfied by the hypothetical reasonable man. However, case law has redefined that standard to be that of the *Bolam Principle* which in substance restrains the courts from scrutinizing and evaluating the professional conduct of a doctor possessed of a special skill and competence and that he is not negligent if he has acted within a practice accepted as proper by a body of his own peers who possess similar skill and competence as the doctor in question. It matters not that there exists another body with a differing opinion that does not accept the action taken by the doctor. It is enough that he had acted in accordance with one of the bodies of opinion and the courts can never declare his action to be in any way negligent. This over protective and deferential approach perhaps conform to the well known phrase that *'A doctor knows best'.*

[27] In the instant appeal, the trial judge did not apply the *Bolam Principle,* preferring instead to question, analyze and conclude that on the evidence before him, the first respondent that caused the paralysis and freed the first respondent of any liability for the appellant's misfortunes. Respondent was negligent in administering a cause of treatment that led to the appellant's paralysis. The Court of Appeal whilst steering clear of making any pronouncement on the *Bolam Principle* nonetheless disagreed with the High Court and concluded there was no evidence to establish with certainty that it was the first surgery performed by the first.

[28] It cannot be disputed that the first respondent was under a duty to advise the appellant on the course of treatment to be undertaken and the risks involved and the issue is whether there has been a breach of that duty.

[29] It is the first respondent's case that the neck injuries suffered by the appellant were as a result of the motorcar accident and if left unattended would lead to paralysis sooner or later. It was under these circumstances that when the conservative treatment proved to be negative that the first operation was performed and when that proved unsuccessful the second operation was undertaken and on both occasions the first respondent had the expressed consents of the appellant to perform both operations.

[30] The expressed consents refer to two consent forms executed by the appellant. The first was signed by her at the time of her admission when it was not even contemplated that surgery was necessary. The second consent form showed her thumb print on the form and bearing a date after the first operation. The trial judge questioned the voluntariness of the thumb print as it was not executed in the presence of a witness as by that time she had lost all sensation to her limbs.

[31] But the issue here is not so much on the consents given for the two operations but on the risks involved and whether the appellant was warned of such risks. She had testified that had she been warned of the risks involved she would not have readily agreed to undergo the first operation.

[32] There was conflicting evidence on this and the trial judge made the following finding when dealing with the appellant's first expressed consent.

> It would also be concluded that at the time when that consent was signed both defendants did not know whether the plaintiff really needed the operation. As such I am of the view that it would not be possible for the second defendant to explain the procedure and the risks of the operation when the consent in the above-stated form was given or signed. For that reason I believe the plaintiff when she said that the second defendant told her that the first operation (open reduction) which took place on 19 July 1982 was a minor operation to correct the little problem of the neck that she was suffering. In other words she was not told of the risk of paralysis coming from that operation.

[33] It must also be remembered that the appellant suffered total paralysis after the first operation and it was to correct this situation that the second operation was performed. In this respect, the trial judge made the following observations:

> As to the first operation, it is clear to me that the second defendant had done something which caused the paralysis. I am satisfied that the paralysis was caused by the wire loop compressing the spinal cord and when the wire loop was removed during the second operation the plaintiff was able to move her upper limbs. It does not matter what explanation the second defendant gave for removing operation was the cause of the paralysis. The second defendant was again negligent when he did not take any step to remedy the paralysis immediately. Instead he waited for two weeks to do the remedial operation and all that time he kept on assuring the plaintiff that she would recover from the paralysis which was only temporary in nature. In my view the above shows that the second defendant failed

to exercise the care and skill of an ordinary competent practitioner in that profession as stated by the Federal Court in the case of *Kow Nan Seng v Nagamah & Ors.* [1982] 1 MLJ 128.

[34] The second defendant referred to by the High Court is the first respondent before us. This is a finding of fact and the law on appellate interference against findings of facts is well settled as to deter us from upsetting such a finding. Moreover, there is sufficient evidence before the court to justify it in concluding as it did. See the cases of (1) *Renal Link (KL) Sdn Bhd v Dato' Dr Harnam Singh* [1997] 2 MLJ 373, (2) *China Airlines Ltd V Maltran Air Corp Sdn Bhd and another appeal* [1996] 2 MLJ 517 and (3) *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635.

[35] More importantly, the facts of the instant appeal differ vastly with the facts in *Bolam* case in that:

(1) Bolam was a mental patient, and unlike the appellant, who has been described as 'a bright young lady' by the Court of Appeal, it is doubtful whether he was in a position to give any consent to any treatment to be given to him;

(2) had a warning of risk been communicated to him, it is also doubtful whether he was in a position to comprehend the true nature of the risks involved;

(3) the risk of injury in the nature of a fracture to Bolam was one in ten thousand. The same cannot be attributed to the appellant as the risk of paralysis was present and real;

(4) unlike *Bolam's* case there is no conflicting body of medical opinion adduced in the instant appeal to establish whether the appellant should or should not be warned of the risks of paralysis.

[36] That said, we are of the opinion that the *Bolam Test* has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

[37] Case law on this aspect of medical negligence has not been consistent in the application of the *Bolam Principle* by the English courts. One such case relates to the House of Lords' dissenting judgment of Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors* [1985] 1 AC 871. The learned judge expressed his observations in the following manner:

> In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.

[38] In that case, Mrs Sidaway suffered personal injuries as a result of a surgical operation done by a neuro-surgeon, Mr Falconer who died five years before the trial of her action. She did not allege negligence on the performance of the operation but rested her case on the failure of Mr Falconer to inform her of the risk inherent on the operation for had she been so warned she would not have consented to the operation.

[39] The case of *Hucks v Cole* [1993] 4 MED LR 393, suggests a shift in attitude when determining a doctor's liability in a given case. The judges in that case adopted a pragmatic approach to this issue and held that it was appropriate for the judges to reject medical expert evidence if they do not really stand up to analysis. The defendant in that case was a general practitioner in Somerset who possessed a diploma in obstetrics. Mrs Hucks had been one of the patients in a maternity hospital and after giving birth to her child, suffered from fulminating septicaemia, which caused various sores and yellow sports on her fingers and toes. Dr Cole put the patient on a five-day course of antibiotics known as tetracycline and it was taken off as the sores were improving. The next day, Mrs Huck contracted septicemia, puerperal fever. She sued Dr Cole for negligence, alleging that he should have treated her with penicillin. The defendant contended that he had acted in accordance with the reasonable practice of other doctors with obstetric experience.

[40] At the trial, Lawton J found Dr Cole to have been negligent and the Court of Appeal upheld his finding. Though the court understood Dr Cole's action couched with a sense of security, the court was willing to apply the test of reasonable care, as to whether the defendant had acted in accordance with approved practice. Based on the evidence, Dr Cole was found to be negligent because he did not take 'every precaution' to prevent the outbreak of puerperal fever and it mattered not if other doctors would have acted as he did. On appeal Sach LJ opined that:

> When risks of greater danger are knowingly taken as a matter of professional practice then, however small the risks, the court must carefully examine the practice, particularly where the risks can be easily and inexpensively avoided.

[41] The decision in *Hucks* was followed in *Gascoine v Ian Sheridan & Co* [1994] 5 Med LR 437 and in another case, *Joyce v Wandworth Health Authority* [1995] 6 Med LR 60 where Overend J commented that:

> The medical practice must stand up to analysis and be unreasonable in the light of medical knowledge at that time.

[42] However, a majority of the cases followed the principles set out in *Sidaway* in which the courts have effectively allowed a doctor's liability to be determined by medical judgment. Nevertheless, the legal position has somewhat changed with the House of Lords' decision in *Bolitho (administratix of the estate of Bolitho (deceased) v City and Hackney Health Authority* [1997] 4 All ER 771.

[43] In that case, the plaintiff a two year old boy, who has a past history of hospital treatment for croup, was readmitted to hospital under the case of Dr H and Dr R. On the following day, the plaintiff had two episodes during which he turned white

and clearly had difficulty in breathing. Dr H was called in the first instance and she delegated Dr R to attend in the second instance but neither attended the plaintiff. At about 2.30pm, the plaintiff suffered total respiratory failure and a cardiac arrest resulting in severe brain damage and subsequently died. The mother continued his proceedings for medical negligence as the administratrix of his estate. The defendant accepted that Dr H had acted in breach of her duty of care to the plaintiff but contended that the cardiac arrest would not have been avoided if Dr H or some other suitable deputy had attended.

[44] Lord Browne-Wilkinson delivering the judgment of the House of Lords expressed his findings at p 778 of the report as follows.

> … In my view the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. …. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

[45] In the course of his speech and after discussing some decided cases, the learned judge also made the following pertinent remarks:

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[46] It would appear that *Bolitho* decided that if it can be shown that the professional opinion relied upon was not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion was not reasonable or responsible.

[47] Commonwealth jurisdictions have also declined to follow the *Bolam Test*. One such case is the Australian case of *Rogers v Whitaker* [1992] 175 CLR 479, where the facts disclose that Whitaker who was almost totally blind in the right eye consulted Rogers, an ophthalmic surgeon. The latter advised her that an operation on her right eye would not only improve its appearance but would probably restore significant sight to it. Whitaker agreed to undergo surgery but it did nothing to her right eye but developed inflammation to her left eye and this led to the loss of sight of that good eye. In the Supreme Court of New South Wales Rogers was held liable in that he had failed to warn Whitaker that as a result of the surgery, she might

develop a condition known as sympathetic opthalmia in her left eye. Rogers' appeal to the Court of Appeal was dismissed and in affirming that decision and following Lord Scarman's ruling in Sidaway, the High Court made the following pronouncements:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam Principle* has not always been applied. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam Principle* has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to *the paramount consideration that a person is entitled to make his own decisions about his life.*

[48] The decision in *Rogers* was followed by the Supreme Court of South Australia in the case of *F v R* [1983] 33 SASR 189 and *Battersby v Tottman* [1984] 35 SASR 577 which rejected the notion that the court is automatically bound by evidence as to the practice of the medical profession. The court has an obligation to question and scrutinize the professional practice, to ensure that the standard set by law is attained. In *F v R* [1983] 33 SASR 189 at p 191, King CJ outlined the scope of the duty to disclose in the following manner:

> Determination of the scope of the doctor's duty to disclose involves consideration of two values which are sometimes in conflict, namely the duty of the doctor to act in what he conceives to be the best interests of his patient and the right of the patient to control his own life and to have the information necessary to do so.
>
> What is in question is the scope of the doctor's duty of care. He is required to act reasonably, not only in his actual treatment of the patient, but also in relation to the disclosure of information. In *Chatterton v Gerson* Bristow J. held that it is *the duty of a doctor to explain what he intends to do, and its implications, in the way a careful and responsible doctor in similar circumstances would have done*. It is my opinion that that is a correct statement of the law, and that the duty extends, not only to the disclosure of real risks of misfortune inherent in the treatment, but also any real risk that the treatment, especially if it involves major surgery, may prove ineffective.
>
> What a careful and responsible doctor would disclose depends upon the circumstances. The relevant circumstances include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient, and the general surrounding circumstances.

[49] This is followed by the following warning from the learned judge as to the reality of the situation:

> But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interest of the clients, but because

A they protect the interests or convenience of members of the profession. The court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law.

[50] In the realm of diagnosis, treatment and the duty to warn, the ruling of the B High Court of Australia in *Naxakis v Western General Hospital & Another* [1999] 162 ALR 540 was able to settle the ongoing doubt which existed in *Rogers vWhitaker,* as to, whether *Rogers* was restricted to cases relating to negligent advice only.

[51] In *Naxakis,* a 12 year old boy, Paraskevas Naxakis was struck on the head by his schoolmate's school bag. He collapsed and was admitted by a general practitioner C to the Western General Hospital for head injury. At the hospital, the appellant fell into unarousable unconsciousness for five minutes and was unresponsive to painful stimuli. A preliminary diagnosis was made of a subarachnoid (traumatically caused) haemorrhage caused by the blow to the head. He remained in hospital for nine days under the supervision of the second respondent, Mr Jensen, a senior neurosurgeon at D the hospital. A CAT scan was carried out which indicated that he was suffering from subarachnoid (traumatically caused) haemorrhage. However, his condition improved and the appellant was discharged. Two days later the appellant collapsed and was taken to the Royal Children's Hospital where he was attended to by Mr Klug, director of neurosurgery. An angiogram conducted revealed that the appellant suffered a E major intracranial bleed from a burst aneurysm. An operation was performed to insert a ventricular peritoneal shunt to drain cerebrospinal fluid and a craniotomy was performed to clip the aneurysm. The appellant brought an action in the Supreme Court of Victoria against the senior neurosurgeon and the hospital for failure to properly diagnose and that his negligence had led him to suffer serious and permanent physical and intellectual impairment. The trial judge accepted a no case F to answer. The appellant's appeal was unsuccessful when the Court of Appeal held that there was no basis for the claim that the neurosurgeon failed to consider the possibility of an aneurysm.

[52] Gaudron J, speaking for the High Court of Australia reaffirmed the rejection G of the *Bolam Test* with the following remarks at p 4 of the report:

> … it is important to bear in mind that the test for medical negligence is not what other doctors say they would or would not have done in the same or similar circumstances … To treat what other doctors do or do not do as decisive is to adopt a variant to the direction given to the jury in *Bolam v Friern Hospital Management Committee (the Bolam rule)*...

H

> The *Bolam rule,* which allows that the standard of care owed by a doctor to his or her patient is *a matter of medical judgment*, was rejected by this Court in *Rogers v Whitaker.*

[53] McHugh J, another member of the panel expressed the same sentiments at I p 12 of the report:

> In my opinion, that evidence of Mr Klug was sufficient to get the plaintiff's case to the jury, irrespective of whether Mr Jensen did or did not consider performing an angiogram. …. If there is evidence upon which the jury could reasonably find negligence on the part of a doctor, the issue is for them to decide irrespective of how many doctors think that the

> defendant was not negligent or careless. Nor is it to the point that this evidence of Mr Klug also shows that a respectable body of medical opinion would not have performed an angiogram in the circumstances of this case. To allow that body of opinion to be decisive would re-introduce the *Bolam Test* into Australian law. In *Rogers v Whitaker,* this court rejected the *Bolam Test* and held that a finding of medical negligence may be made even though the conduct of the defendant was in accord with a practice accepted at that time as proper by a responsible body of medical opinion.

[54] The question before the High Court of Australia was not whether the defendant's conduct accorded with the practice of the medical profession or some parts of it, but whether it conformed to the standard of reasonable care demanded by the law. That was the question for the court, and the duty of deciding it could not be delegated to any profession or group in the community.

[55] In Malaysia, the *Bolam Principle* has been applied extensively by the courts in medical negligent cases when determining the standard of care. Such cases include:

(1) *Swamy v Matthews* [1967] 1 MLJ 142;

(2) *Swamy v Matthews* [1968] 1 MLJ 138;

(3) *Chin Keow v Government of Malaysia and Another* [1967] 2 MLJ 45;

(4) *Elizabeth Choo v Government of Malaysia* [1970] 2 MLJ 171.

(5) *Kow Nam Seng v Nagamah & Ors* [1982] 1 MLJ 128.

[56] In the last mentioned case, the appellant applied a complete plaster case to the leg of the second respondent and due to lack of proper skill and care in the application of the cast, caused inadequate blood circulation to the leg, that led to gangrene, necessitating the amputation of the second respondent's leg. The second respondent claimed damages against the appellant, third respondent and the government. The appellant admitted liability as regards the road accident but denied it as regards the amputation. The trial judge absolved the medical officer and the government from any blame and held the appellant solely to blame. Salleh Abas FJ in delivering judgment for the Federal Court said at p 130:

> There may be differences of opinion as to the types of plaster casts to be applied in the treatment of the type of injuries sustained by the respondent, but the choice of a treatment which is the standard medical practice is not by itself a negligence, *Bolam v Friern Hospital Management Committee* [1957]2 All ER 118 and *Elizabeth Choo v Government of Malaysia* [1970] 2 MLJ 171.

[57] In *Asiah bte Kamsah v Dr Rajinder Singh & Ors* [2002] 1 MLJ 484, the plaintiff delivered her second child on 10 October 1988 at the Telok Intan District Hospital. Due to suspicion of foetus distress, she underwent a lower section caesarian operation done under general anaesthesia. Unfortunately, she did not recover from the operation and suffered permanent irreversible brain damage. The plaintiff claimed damages against the defendants. In deciding whether the doctor and the anaesthetist were negligent, the court relied on the *Bolam Principle*. James Foong J (as he then was) concluded as follows at p 489 of the report.

> …. I find no evidence to support a finding that this doctor was negligent in this surgery going by the test set out in the established case of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118

[58] Later at p 494 of the same report, the learned judge made the following finding as against the second doctor sued in that action.

> …. I find the second defendant is guilty of negligence since he did not act in accordance with the practice accepted as proper by a responsible body of medical men skilled in this particular art — a test as set forth in *Bolam's* case.

[59] Later in the same year, the court in *Hor Sai Hong & Anor v University Hospital & Anor* [2002] 5 MLJ 167,applied the *Bolam Principle* in deciding whether the doctor was negligent in handling the birth of the second plaintiff's child. Following the decision of the *Rogers*' case in 1992, conflicting judgments have been delivered in our courts over the preference and application of the *Rogers v Whitaker* test to the *Bolam Test.*

[60] In *Liew Sin Kiong v Dr Sharon DM Paulraj* [1996] 5 MLJ 193, the plaintiff sued the defendant for aggravated or punitive damages for negligence pertaining to the operation of his right eye which was lost to post-operative infection. The plaintiff also alleged that a Seton procedure, which the plaintiff's first doctor had recommended should have been carried out, and not a repeat trabeculectomy which the defendant had performed.

[61] Ian Chin J followed *Sidaway* and found that the plaintiff had failed to prove that the defendant had not acted in accordance with the standards of a competent ophthalmologist. The defendant was held not liable and in so deciding, the learned judge made the following remarks at p 209 of the report.

> I am of the view that the defendant had treaded on well trodden path and she cannot be said to be guilty of negligence (*Bolam v Friern Hospital Management Committee* [1957]2 All ER 118, HL). Put in another way, the plaintiff has failed to prove that the defendant did what no skilled ophthalmologist would do (*Hunter v Hanley* [1955] SC 20, *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171.

[62] The *Rogers v Whitaker* test was fully endorsed in Malaysia for the first time in the case of *Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor* [1996] 4 MLJ 674. The brief facts in this case are that the the late Mr Dinasan a/l Padmanbathan, the deceased, who was employed by the first defendant at the time of his death, was suffering from hypertension. He complained of giddiness and fits and fainted at work. He was then attended by the defendant's doctor who examined him and prescribed medication and subsequently discharged him. He was further examined by the defendant's doctor on two other occasions. A day after his last examination, the deceased was admitted to the Kluang Hospital as a result of giddiness and fits. The deceased died at the Kluang Hospital the day after.

[63] Richard Talalla J, at p 686 of his judgment had this to say: A

> The law applicable in this case and which binds me is to be found in the majority decision of Barakbah LP in the Federal Court case of *Swamy v Matthews & Anor* [1968] 1 MLJ 138 at pp 139 and 140 where it was stated: 'A man or a woman who practices a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession — be it the profession of an accountant, a banker, a doctor, a solicitor or otherwise. B

Further, at p 6, his Lordship went on to say:

> … that the current state of the law, by way of elaboration may be found in the decision of the High Court of Australia given in *Christoper Rogers v Whitaker* [1992]175 CLR 479. C

Finally, at p 6, his Lordship concluded as follows:

> For my part I see *Bolam's* case and that of Elizabeth Choo being referred to by the learned judge not for a proposition that there being differences of opinion as to treatment, choice of a treatment which is the standard medical practice is not itself negligence. I do not see the learned judge as having addressed himself to the *Bolam principle* and upon doing so D applying it. Accordingly, I do not find myself by reference to *Kow*'s case being fettered by the *Bolam Principle* but on the contrary bound by the ruling of Salleh Abas FJ, set out above which ruling corresponds with the ruling by the then Lord President in Swamy's case and I propose to adopt by way of elaboration of those rulings the abovementioned dicta extracted from the decision in the *Rogers*' case. I should emphazise that while due regards will be had to the evidence of medical experts, I do not accept myself as being restricted by E the establishment in evidence of a practice accepted as proper by a responsible body of medical men skilled in that particular art to finding a doctor is not guilty of negligence if he has acted in accordance with that practice. In short I am not bound by the Bolam principle. Rather do I see the judicial function in this case as one to be exercised as in any other case of negligence, unshackled, on the ordinary principles of the law of negligence and the overall evidence. F

Rogers v Whitaker was again applied in the case of *Tan Ah Kau v The Government of Malaysia* [1997] 2 AMR 1382. In this case, the servant and/or agent of the defendant carried out a surgical operation on the plaintiff who had a history of an injury to his back caused by a piece of wood. The provisional diagnosis was that of a prolapsed disc. An orthopedic surgeon examined the plaintiff and made a provisional diagnosis G of intra spinal tumor at the level of the thoracic vertebra D11 and D12. After numerous tests, the cause of the tumor was ascertained as low grade astrocytoma. He was completely paralysed waist down. The plaintiff sought damages from the defendant for the alleged negligence and/or breach of professional duties. H

[64] In applying the *Rogers v Whitaker* test, Low Hop Bing J (as he then was) arrived at the following conclusion at p 1402 of his judgment.

> In the instant case, where the risk of paralysis was very real, more so than the tumor was intramedullary, it was absolutely essential for the attending surgeon such as DW1 or any doctor assisting him to warn the patient of the foreseeable risk of even a finding of I intramedullary tumor.

[65] Finally, we make reference to Michael Jones' book on *Medical Negligence* [1996] ed, p 95 that seems to suggest that there is a distinction between the test of

negligence based on the reasonable competent man and that of the ordinary skilled man. The former makes it clear that negligence is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor' and the latter places considerable emphasis on the standards which are in fact adopted by the profession. He emphasizes that the point is for the court to determine what the reasonable doctor would have done, not the profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented. The *Bolam Test* fails to make this important distinction between the reasonable competent doctor and the ordinary skilled doctor.

[66] In *Blenkiron v Great Central Gas Consumers' Co* [1860] 2 F & F 437, Cockburn CJ, said:

> General practice has always been taken into account in determining the standard of care, but it is not conclusive because 'no one can claim to be excused for want of care because others are careless as himself'. …. Indeed it is not so much the universal behaviour of mankind in a particular field to which the law gives weight, as the standard of conduct whether uniformly followed or not, which is generally accepted as correct.

[67] In *Hajgato v London Health Association* [1982] 36 OR(2d) 669,, an action in negligence in respect of personal injuries sustained during post-operative case, Callaghan J, at p 693 of his judgment expressed his concern in the following manner:

> In my view however, a court has a right to strike down substandard approved practices when common sense dictates such a result. No profession is above the law and the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards.

[68] In the Irish case of *Best v Wellcome Foundation Ltd* [1994] 5 Med LR 81, Finlay CJ expressed the same concern and defined the *'function which a court can and must perform in the trial of a case in order to acquire a just result, is to apply common sense and a careful understanding of the logical and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind'.*

[69] Therefore, there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium then the *Bolam Test.* To borrow a quote from Lord Woolfe's inaugural lecture in the new Provost Series, delivered in London in 2001, the phrase *'Doctor knows best* should now be followed by the qualifying words *'if he acts reasonably and logically and gets his facts right'.*

[70] On that finding, we answer the question posed to us in the negative and order that this appeal is allowed with costs here, in the Court of Appeal and in the High Court to be borne by the respondents and the orders of the High Court on quantum are to be restored. The deposit is to be refunded to the appellant.

[71] Finally, we wish to add that this judgment is delivered pursuant to s 78(1) Courts of Judicature Act 1964 as the Chairman of the panel has since retired.

Appeal allowed.

Reported by Loo Lai Mee